DOCUMENT RESUME

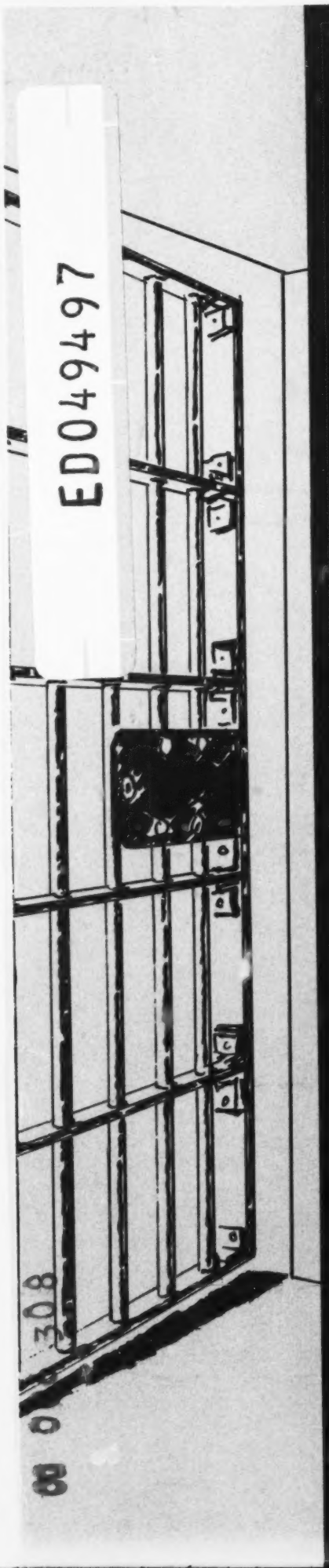
ED 049 497 CG 006 308

AUTHOR	Glaser, Daniel; O'Leary, Vincent
TITLE	The Control and Treatment of Narcotics Use. Parole Decision Making.
INSTITUTION	National Parole Institutes.; Social and Rehabilitation Service (DHEW), Washington, D.C.
PUB DATE	68
NOTE	43p.
AVAILABLE FROM	Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402. ($0.20 per copy)
EDRS PRICE	EDRS Price MF-$0.65 HC Not Available from EDRS.
DESCRIPTORS	*Behavior Change, Drug Abuse, *Drug Addiction, *Drug Legislation, *Drug Therapy, Group Counseling, Individual Differences, Medical Treatment, *Narcotics, Physiology

ABSTRACT

After a brief discussion of the physiological effects of drugs on the human body, seven distinctive features of drug usage in the United States since the start of World War II are noted, and initiation into drug usage is described. The notion of a distinct personality type of addicts is not favored since terms used to characterize the type are not precise, but rather a matter of degree. A review of legislation on the handling of narcotics is given, and several explanations are given for the difficulty in suppressing narcotics traffic. Finally, the controversy over whether drug usage should be considered purely an illness, strictly a crime, or a combination of both is discussed. The methods most widely employed, usually in combination, to combat narcotics use are described. These include: (1) imprisonment; (2) hospitalization, with medical and psychological services; (3) institutional group counseling; (4) community surveillance and testing; (5) casework programs in the community; and (6) mutual aid organizations of ex-addicts. (TA)

ED049497



PAROLE DECISION-MAKING

The Control and Treatment of Narcotic Use

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION
THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL OFFICE OF EDUCATION POSITION OR POLICY

U. S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Social and Rehabilitation Service
Office of Juvenile Delinquency and Youth Development

1

ED049497

The Control and Treatment of Narcotic Use

By
DANIEL GLASER
and
VINCENT O'LEARY

for the
NATIONAL PAROLE INSTITUTES

U. S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Social and Rehabilitation Service
Office of Juvenile Delinquency and Youth Development

CG 006 308

The National Parole Institutes are administered by the National Council on Crime and Delinquency, a national nonprofit organization devoted to the prevention and control of crime and delinquency. The Institutes are cosponsored by the Advisory Council on Parole of the National Council; the Association of Paroling Authorites; the Interstate Compact Administrators Association for the Council of State Governments; and the U.S. Board of Parole.

The Parole Institutes, including the preparation of Institute materials, have been supported by grants from the Office of Juvenile Delinquency and Youth Development, Welfare Administration, U.S. Department of Health, Education, and Welfare.

The views expressed in this document do not necessarily reflect the position and policy of the Department.

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 Price 20 cents

FOREWORD

September 1, 1962, marked the beginning of a continuing program of intensive, nationwide institutes for members of parole authorities and top-level parole administrators concerned with the treatment of youthful offenders. The basic aim of the Parole Institutes is to provide an opportunity for a systematic exchange of information and mutual examination of problems among parole officials. Leaders of the Institutes include representatives from the fields of sociology, social work, psychiatry, psychology, and law.

All of the Parole Institute publications have been prepared as resource material to be made available to participants in the Institutes. The Office of Juvenile Delinquency and Youth Development is very glad to work with the National Council on Crime and Delinquency, and to reproduce several of the Parole Institute publications so that the materials may reach a wider audience. It is hoped that these will assist in the national effort to develop more effective solutions to the continuing task of combating delinquency and youth crime.

It is difficult to designate any one sector of the rehabilitative or correctional process as the most crucial. Yet, it is inescapable that the fruition of all the rehabilitation efforts rests on the linkage between the offender and the community to which he returns. The last step in this process is parole. It is the opportunity to reinforce the positives of the rehabilitation process and to counteract the negatives. It is the strategic position that parole occupies in the correctional process that makes it urgent to refine the system so that it may, in fact, carry out its important function.

This volume is concerned with the treatment of those involved with the use of narcotics. The document was written by Dr. Daniel Glaser, Department of Sociology, University of Illinois, with the assistance of Mr. Vincent O'Leary, Director of the National Parole Institutes. In the first sections, the authors describe the physiological effects of narcotics, modern social changes in drug use, personality traits of narcotic users, and the suppression of narcotics. The final part reviews several alternative forms of treatment currently being attempted.

CONTENTS

	Page
Foreword	iii
I—The Physiological Effects of Narcotic Drugs	1
II—Midcentury Changes in Drug Use	7
III—Initiation into the Drug Habit	11
IV—Personality and Narcotics Use	15
V—The Suppression of Narcotics	21
VI—Alternative Treatments for Narcotics Use	29

PART I—THE PHYSIOLOGICAL EFFECTS OF NARCOTIC DRUGS

Perhaps the most adequately confirmed knowledge available on the drug problem pertains to the physiological effects of the drugs. The chemicals classified as narcotics fall into two main categories in terms of their effects on the human body. Those most commonly involved in illegal use are "depressants," so called because, if taken in sufficient quantity, they affect the central nervous system in such a way as to slow up bodily functions and lower body temperature. The principal depressants are opium and its derivatives (such as morphine, heroin, and codeine), marihuana, and the barbituates. Alcohol and tobacco also are physiological depressants. The other category of narcotic drugs consists of the stimulants, which raise the body's nervous and muscular tone and keep one awake. Cocaine and benzedrine are the principal stimulants among drugs involved in illegal use. Coffee and tea are also stimulants to a much lesser degree.

Opium in its original form consists of the seed capsules of the Oriental poppy plant. These have been smoked or eaten for their depressant effects, particularly in the Orient, since ancient times. Morphine, a chemical derived from opium, was first isolated in 1804 and has been invaluable in medicine as a pain killer. In recent years morphine has been replaced in medicinal usage by synthetic opiate drugs, notably demerol, which has fewer toxic side effects than morphine. Codeine is a morphine derivative commonly used in cough syrups.

Heroin is a morphine derivative used by over 90 percent of the persons convicted of felonious drug usage in the United States in recent decades. Because of this association of heroin with illegal narcotics usage, and because it has no advantage over other available drugs in medical treatment, the manufacture and distribution of heroin is not permitted for medical purposes. Heroin generally is used by drug addicts in a mixture of about 2 percent heroin and 98 percent lactose (milk sugar). The addict dissolves this mixture in a spoonful of water, heats it slightly, and injects it into his veins. It may also be sniffed in through the nostrils in powdered form. Especially when injected, it has unusually rapid and pronounced effects.

Marihuana is prepared from the flowers and leaves of several varieties of hemp plant. An Oriental variety, known as hashish, has been smoked since the dawn of history and is mentioned in the Bible.

These plants grow wild in most of the United States, although a large proportion of marihuana prepared for smoking is illegally imported from Mexico. It generally is used as a cigarette. Its effects are reported to be much like those of alcohol. One cigarette deeply inhaled, in the special manner favored by this drug's users, is said to be comparable in effect to one "shot" glass of whiskey.

The barbiturates are a relatively recent source of addiction, and it is only within the last 15 or 20 years that barbituratism has been recognized as a "true addiction." Barbiturates are salts of bartituric acid and were first prepared in 1903 by Fischer and Von Mering. The most common barbiturates today have special names (coined by the manufacturers) ending in *al* to show their relationship to barbital.

Barbiturates are commonly prescribed as sleeping pills and are useful depressants of the central nervous system. Taken in small amounts under direction of a physician, they produce no ill effects, but, when taken in large and uncontrolled amounts, they become dangerous and intoxicating drugs. Barbiturates differ from the other addicting drugs in that they are comparatively easy to obtain, while other drugs in nonmedical use are dispensed primarily through underworld sources.

More deaths are caused by overdoses of barbiturates—taken either accidentally or with suicidal intent—than by any other poison except carbon monoxide. How many persons take these drugs habitually is not known, but, in 1955, 864,000 pounds were manufactured in the United States alone, amounting to approximately 26 doses for every man, woman, and child in the population, according to Public Health Service Publication No. 545. Even where sale is restricted to prescription only, it is possible, and not unusual, for addicts to obtain prescriptions from more than one physician in the same city or different towns.

Cocaine comes from the South American cocoa tree. It was first produced in 1853, and its use in medical practice increased tremendously toward the end of the 19th century. Classed in the stimulant or excitant group of drugs because of its effect upon the nervous system, cocaine is used principally in medicine as a local anesthetic. It desensitizes sensory nerve endings, but because of the effects of continued use—mental deterioration, nausea, digestive disorders, sleeplessness, loss of appetite, emaciation, and tremors—it has been replaced in medicine by procaine and novocaine.

Cocaine, because of its toxicity, is rarely used hypodermically; addicts prefer to sniff the cocaine powder, commonly known as snow, through the mucous membranes of the nose. Frequently, the addict prefers the "speedball," or a mixture of cocaine and heroin, which blends the shock power of cocaine with the extended afterglow of heroin and permits the experienced addict to "go fast slow." Cocaine

addiction is very rare today inasmuch as the drug is so scarce on the illicit market. International movement of cocoa leaves is strictly controlled, and Peru, formerly the primary source of the drug, has closed all cocaine factories.

The more recent chemical discoveries, amphetamines, desoxyphedrines, and related drugs, manufactured under various trade names, are considered potentially harmful by Federal authorities, as well as by representatives of pharmaceutical groups and medical experts. Some are actually classified under the Federal Food, Drug, and Cosmetics Act as dangerous.

Amphetamines, unlike the opiate drugs, do not produce physical dependence or withdrawal illness, but prolonged use leads to a more or less permanent state of nervousness and often causes emotional dependence. Intoxication from some actually produces hallucinations and delusions similar to those brought on by cocaine intoxication.

Many other substances are employed as narcotics or quasi-narcotics. Their variety has become so great, and the rate of innovation so rapid, that it is hard to define them all legally and to impose restrictions which will affect only their improper distribution or use. Indeed, even the most ordinary and useful drugs, such as aspirin, sometimes are taken in excess to produce a peculiar sensation, and they may even be fatal. Also, many substances not generally considered drugs, such as plastic glues from model airplane kits, paint thinners, and various spices and herbs, are sniffed, eaten, smoked, or injected to induce peculiar moods or sensations, sometimes with unhealthy or deadly consequences.

Addiction and Habituation

Much confusion exists in the use of the terms "addictive" and "habit-forming" when describing the effects of drugs. In its most narrow physiological usage, the term "addictive" is only clearly applicable to opium and its derivatives, and to the barbiturates, among the more widely used narcotics. In this sense, an "addictive" drug is one for which the body develops:

(a) *Tolerance:* The biochemical condition of the addicted person becomes such that he can take a larger dosage of the drug than most persons could take without pronounced ill effects, or he has to take more to experience a given effect. His body has adapted to the presence of the drug so that it is more "normal" when it contains this drug, than it would be if he took the drug when not addicted. Often he can take a dosage which would kill a nonaddicted person.

(b) *Withdrawal Effects:* When the drug is oxidized in an addict's body, or is eliminated, and is not replenished, severe physiological maladjustment occurs which can be relieved only by intake of the addicting drug. Because of the withdrawal

315-970 O - 68 - 2

effects and their relief by the narcotic, this feature of addiction is sometimes referred to as "physiological dependence." The disorder on withdrawal is also known as "abstinence syndrome." Of course, if a person survives the withdrawal effects, he may eventually become adjusted to normal health without the drug. He is only clearly addicted, in this narrow sense, during the period in which his body still has clearcut tolerance and physiological dependence.

Most of the confusion regarding the concept of addiction comes from the fact that the purely organic and the psychologically induced effects of drugs are so intermingled in human experience. Sensations associated with taking drugs, or with almost anything else which humans consume, are not derived just from the chemical effects of the substances on the human organism; they also come from the suggestions the user may receive about what the effects will be, and from his moral or aesthetic interpretation of this experience, conscious or unconscious.

Many substances can be eaten, drunk, chewed, or otherwise manipulated so habitually that a person becomes highly uncomfortable without them, even when he does not have any clear physiological dependence on them. These include coffee, tea, tobacco, chewing gum, candy, and even breakfast eggs or orange juice. Therefore, the terms "habit-forming" and "addiction" have acquired considerable overlap in common usage. Sometimes a broad conception of addiction adds "habituation" to tolerance and dependence for a three-trait definition. Habituation may also be called psychological or emotional dependence, as distinct from physiological dependence. Ausubel adds "euphoria," or positive psychological satisfaction, to tolerance and physiological dependence as primary characteristics of addiction.[1]

Persons regularly using marihuana, alcohol, tobacco, coffee, tea, and other substances—sometimes even candy or chewing gum—regularly claim to experience a disturbance from withdrawal of such substances, which is relieved by further use of the same item. However, clear physiological disturbances, relieved only by the same or a similar substance, are not found when these products are given to laboratory animals. This is a major source of rigorous evidence that most nonopiates commonly called "habit-forming" are not addictive in a physiological sense like the opiates. There are conflicting opinions in the medical literature as to whether purely physiological dependence on alcohol develops at all; it has not been demonstrated in animals,[2] and

---

[1] David P. Ausubel, *Drug Addiction*, New York: Random House, 1958, pp. 9–10, 20–30. David Maurer and Victor H. Vogel, *Narcotics and Narcotic Addiction*, Springfield, Ill.: C. C. Thomas, 1954, pp. 22–28. For the more narrow use, see, for example, Roger Adams, "Marihuana," *Bulletin of the New York Academy of Medicine*, vol. 18 (November 1942), pp. 705–730.

[2] E. M. Jellinek, *The Disease Concept of Alcoholism*, New Haven, Conn.: Hillhouse Press, 1960, p. 43.

if it exists in human beings, it certainly is not as clear and marked as opiate dependence. Barbiturates appear definitely addictive in all meanings of the term, although not as clearly as the opiates.[3]

The second major source of rigorous data on the intermingling of psychological and physiological effects from these drugs comes from research in which human beings at times received injections of opiates or other drugs, and at other times injections of an inert "placebo" solution. They never knew what they were getting and always assumed it to be some drug. It is interesting that when morphine was injected in this fashion, there were consistent reports by most recipients that it made them feel depressed in mood, or dysphoric. Incidentally, the researchers observed that most medical textbooks, from carelessly accepting reports of persons taking morphine under less controlled conditions, ascribe euphoric effect of this drug, in addition to its relief of pain. However, with all the drugs tested and with the inert placebo, the same subjects, a small proportion of all participants, reported various effects on mood which clearly differed from those reported by most subjects. These persons with atypical responses had previously been diagnosed as the least balanced emotionally of the subjects in these tests.[4]

The foregoing suggests that unstable persons are particularly prone to develop psychological reactions to both presumed and actual physiological changes in their body, and the latter often may be more than counteracted by the former. Some reactions of this sort are normal. A similar phenomenon is familiar in the variety of reactions which people display to the presence of alcohol in their bodies. This varies from hostility to affection, and from gaiety to depression, as a function of both personality and social situation.

The psychological and social effects of narcotic drugs probably are more important than the physiological effects in accounting for their postrelease use by individuals whom parole boards face. Persons who return to narcotics after being imprisoned or hospitalized long enough to be in good health when released clearly are not physically dependent upon the drug. If they resume narcotics usage, it is not as a relief from withdrawal effects. They clearly crave the drug for some other reason. Similarly, the difficulty which many people have in giving up the use of alcohol, tobacco, or coffee, where there definitely is not a clear physiological dependence, suggests that the term "habit-forming"

---

[3] H. Isbell, "Addiction to Barbiturates and the Barbiturate Abstinence Syndrome," *Annals of Internal Medicine*, vol. 23 (July 1950) p. 108; National Institutes of Health, *Barbiturates as Addicting Drugs*, Public Health Service Publication No. 545, Washington, D.C.: U.S. Government Printing Office, 1957.

[4] Louis Lasagna, John M. Von Felsinger, and Henry K. Beecher, "Drug-Induced Mood Changes in Man," *Journal of the American Medical Association*, vol. 157 (March 19 and March 20, 1955), pp. 1006–1020, 1113–1119.

may be quite descriptive of factors other than physiological dependence involved in drug usage. Additional factors in much of this persistent drug usage are social. This will be described later.

While most of the narcotic drugs can seriously injure a person or kill him if taken in an overdose, it is not clear that a regular but limited dosage shortens life or has other pronounced ill effects. This, of course, can also be said of alcohol, and until the recent statistical correlations of tobacco smoking with lung cancer, it was also said of tobacco. Certainly, there are many people who live to an old age smoking and drinking daily, and conversely many have serious illness and an early death from excessive regular use of alcohol. Dr. Laurence Kolb, former head of the U.S. Public Health Service, reports a case of an 84-year-old physician who claimed to have taken a daily injection of morphine for 62 years.[5] Before World War I, when there was no restriction on the sale of opiates in the United States, there was much addiction among Civil War veterans who, when wounded, had been issued morphine to administer to themselves.[6]

---

[5] Laurence Kolb, "Let's Stop This Narcotics Hysteria," *Saturday Evening Post* (July 28, 1956).

[6] Maurer and Vogel, *op. cit.*, p. 6.

PART II—MIDCENTURY CHANGES IN DRUG USE

In Europe throughout this century, and in the United States before the 1940's, most drug addiction occurred among middle-aged and older persons who were not of the lowest economic status. A major portion of the addicts were alleged to have been introduced to the drug habit through medical sources. These users included many nurses, pharmacists, and physicians, as well as some individuals for whom drugs originally were prescribed for medical purposes, but who remained addicts after their ailments were cured. There was also a cult of artists of various sorts using narcotic drugs experimentally, in search of unique experiences. These included prominent writers, painters, and musicians. Also, throughout the 20th century, drug use has been associated with professional playing of jazz music.

Seven distinctive features of drug usage in the United States since the start of World War II are noteworthy. One of these is the increase in drug use by younger persons. This is indicated in table 1, which despite the changes in completeness of reporting to the FBI, shows a fairly steady trend of increase in persons under 18 among narcotics arrestees, and decrease in persons over 40.

A second trend is an increase in the extent to which drugs are used by persons of the lowest economic status. Related to this is a third trend, the concentration of drug usage in persons of minority racial and national groups. In the large cities of Northeastern United States, especially New York and Chicago, Negroes have comprised over 90 percent of those arrested for narcotics, and the usage has been concentrated in the poorest sections of the Negro slums. In Southwestern United States, in the Los Angeles area, those apprehended for narcotics use are more ethnically diverse than in most other large cities; they include large proportions of whites, Negroes, and persons of Mexican descent. The concentration in large cities appears to be a fourth trend of the midcentury decades. Most commitments to U.S. Public Health Hospitals for addiction in the 1930's were from Southern States, from rural areas and small towns, whereas a majority now are from New York City.

A fifth postwar development has been the widespread linkage of different types of drug use. Apparently, smoking marihuana was spread in minority groups in the 1930's, and around the end of that decade a pattern of progressing from marihuana to heroin was com-

Table 1—Age Distribution of Persons Arrested for Narcotics Offenses in U.S. Cities 1940–62

Year	Median age	Percentage distribution by age group										Total cases reported (100 percent)
		Under 16	16	17	18	19	20–24	25–29	30–39	40–49	50 and over	
1962	27.2	3.8	1.7	2.5	3.1	3.9	25.2	22.6	27.1	7.2	2.9	29,068
1961	26.3	2.7	1.5	2.6	3.5	4.3	27.2	22.5	25.7	6.8	3.3	25,080
1960	27.2	.8	1.2	2.1	3.4	4.2	27.5	24.4	26.7	6.4	3.2	23,430
1959	27.8	.9	1.2	2.2	3.2	3.5	25.0	24.6	28.4	7.7	3.3	10,662
1958	27.8	.9	1.1	1.9	2.9	3.5	24.8	26.3	27.1	7.7	3.9	9,863
1957	27.8	.5	.8	1.8	2.6	3.2	25.6	27.9	25.9	7.8	3.9	7,277
1956	27.3	.8	1.3	1.9	2.4	3.2	27.3	28.6	23.0	7.4	3.9	7,289
1955	27.7	.9	1.0	1.7	2.3	3.1	27.2	27.9	24.6	8.0	4.3	6,888
1954	27.5	.4	.7	1.3	2.8	3.5	27.3	27.8	23.0	8.3	4.9	6,634
1953	26.7	.9	1.2	2.1	3.6	4.7	28.8	25.5	20.6	8.1	4.5	5,681
1952	27.3	.4	.8	2.0	2.9	3.4	30.4	23.7	23.6	9.3	5.5	3,013
1951	26.0	.3	1.0	2.3	4.1	5.3	32.5	22.5	19.0	8.3	4.5	13,030
1950	26.3	.3	.9	1.8	3.6	5.6	32.6	21.0	19.5	9.5	5.5	8,539
1949	27.2	.1	.4	1.0	3.4	5.1	31.1	19.9	21.7	11.5	5.7	6,546
1948	27.5	.1	.4	.9	4.5	5.9	28.8	18.6	21.7	12.9	6.0	4,846
1947	28.6	.1	.4	1.0	4.1	6.1	25.4	17.8	23.6	14.4	6.7	3,388
1946	30.2	.1	.3	1.2	3.3	3.7	22.4	18.5	25.9	16.9	7.5	2,807
1945	32.6	.1	.4	1.0	3.2	3.3	18.9	15.3	29.2	18.9	9.9	1,935
1944	33.6	.1	.2	1.2	2.1	2.6	17.9	15.7	28.8	21.3	10.2	1,731
1943	34.4	.2	.4	.7	1.8	2.6	15.0	16.9	28.1	23.6	10.7	1,361
1942	35.5	.2	.4	.7	2.3	1.5	12.0	15.8	31.2	26.0	9.8	1,123
1941	31.3	.2	.3	1.3	2.2	3.3	19.8	19.4	27.8	16.2	7.5	2,593
1940	31.3	.2	.5	.8	2.3	2.9	20.2	19.5	28.0	17.5	8.1	5,014

Compiled from Federal Bureau of Investigation, *Uniform Crime Reports*. Note that before 1952 these figures were compiled by the FBI from individual arrest reports submitted for its fingerprint files, while from 1952 on, the reports were compiled by the separate police departments, then submitted as annual tabulations. A progressive increase in the number of cooperating police departments occurred in both the pre- and post-1952 periods, except for war years.

mon. Both of these drugs are distributed exclusively through criminal channels, whereas in the 1930's and earlier, narcotics used by older addicts of higher social and economic status, were more often drugs illegally diverted from their normal distribution for medical use. There still are many who use marihuana but never try opiates, and an appreciable fraction of opiate addicts have never used marihuana.

A sixth trend in the 1940's and 1950's was the increased association of drug addiction with other types of criminality. Not only did most persons arrested for drug use have a record of other types of delinquency before they became involved with drugs, but the high cost of the drugs and their low incomes made it necessary for them to support the narcotic habit by procuring a criminal income.[1] The fact that

[1] This trend has been the major source of some disagreement in the literature as to whether delinquency and crime generally precede narcotic addiction, or only follow it, as a means of supporting the habit. Tabulations of the pre-World War II criminal records of addict patients in the U.S. Public Health Service Hospitals suggested that 75 percent got their first convictions for narcotics rather than for other criminal offenses. However, more recent tabulations of arrest records of addicts in custody of police or correctional agencies, and studies of

heroin was imported and distributed completely through criminal channels, and was highly profitable, apparently led to the distributors soliciting sales in the slums, where they were in contact with delinquents and other criminals.

A seventh trend, especially prominent in the 1960's, was use of new types of drugs. Notable here are use of a large variety of pills, including several new and dangerous drugs, LSD and other "hallucinogenic" drugs, and the glue-sniffing fad among juveniles.

---

hospitalized juvenile addicts by psychologists and sociologists, suggest that most addicts today were non-drug-using delinquents before they were addicts. Ausubel, *op. cit.*, Chap. 8; Isidor Chein, "Narcotics Use Among Juveniles," *Social Work*, vol. 1 (April 1956), pp. 50–60; I. Chein and Eva Rosenfeld, "Juvenile Narcotics Use," *Law and Contemporary Problems*, vol. 22, No. 1 (Winter 1957), pp. 52–68; Harold Finestone, "Narcotics and Criminality," *Ibid.*, pp. 69–85; H. J. Anslinger and W. F. Tompkins, *The Traffic in Narcotics*, New York: Funk and Wagnalls, 1953, p. 170.

PART III—INITIATION INTO THE DRUG HABIT

The process of introduction to drug use has been vividly described by several researchers. Becker notes that persons become habituated to the use of marihuana only through: (1) meeting people who will teach them how to use it by deep inhalation, rather than by ordinary smoking, to produce marked physiological effects; (2) using it in a social situation where these physiological effects are interpreted by others as evidence that the user is "high" and is supposed to feel happy, even though the physiological effects may often include dizziness and nausea; (3) defining the overall effects of the total experience, including the social situation, as pleasurable.[1] Each of these steps is promoted by the others and all reflect the "party" setting where this use usually occurs. Similarities to the introduction of many individuals to excessive use of alcohol will be noted.

As Becker also has pointed out, the illegality of narcotics has social consequences which may promote persistence in drug use. First of all, to get the drugs the user must become familiar enough with persons already using them, or selling them, to win their confidence. Secondly, because their use is criminal, drug-taking must be concealed from nonusers; it is generally done only when or where conventional persons are not likely to observe it, so that users create a social world increasingly out of contact with nonusers. Thirdly, since use of the drug generally is defined as immoral, the user has to develop a special rationalization to justify its use to himself.[2]

Drug users frequently rationalize their habit to themselves by denying that there is anything evil in the drug, finding immorality and hypocrisy in conventional persons, and thinking of themselves as having an unusual aesthetic experience which "squares" are incapable of appreciating. Another important feature of the rationalization is to insist to themselves and to others that they are "not really hooked," but could give it up if they wished. A fourth factor in the social involvement of the narcotics initiate with other users is the fact that his first drugs generally are received as a gift from a more experienced

---

[1] Howard S. Becker, "On Becoming a Marijuana User," *American Journal of Sociology*, vol. 59, No. 3 (November 1953) pp. 118–124.

[2] Howard S. Becker, "Marijuana Use and Social Control," *Social Problems*, (July 1955), pp. 35–44.

315-970 O - 68 - 3

user. This creates an obligation to reciprocate, which means that the initiate must maintain this contact, or make new contacts, to purchase his own supply.

Finestone has pointed out that the ideas that a superior sensitivity and a unique experience are involved in drug-taking, ideas with which drug users rationalize their practice, are particularly attractive to "marginal men" who have not been very successful in fulfilling their aspirations for achievement in the conventional world. This may explain why the drug habit attracts adolescents, especially those previously involved in delinquency, and thus handicapped in achieving their adult aspirations. It may also suggest a reason for the attraction of drug use to minority groups, who suffer frustration in their ambitions for high status occupations and prestigeful social life. In place of the sense of failure which these conditions may foster in such "marginal men," the "cat culture" of the drug users, with its special language and lore, may offer a sense of having some type of superiority, from sharing esoteric knowledge and pleasures. From this standpoint, the drug use is viewed by addicts not just as an escape, but as some kind of achievement.[3] It may explain their return to it after confinement, even when they have long been cured of tolerance and withdrawal effects.

In talking with drug users, whom they interviewed at Chicago's Institute of Juvenile Research in the early 1950's, Kobrin and Finestone distinguished three stages of involvement in heroin addiction. The first they called the "joy popper," where the individual has had an occasional small dose and has not experienced marked withdrawal effects. The second stage they called the "frantic junkie," where the offender has taken sufficient drugs to have very clear withdrawal effects, but has not established a regular pattern of drug procurement. These are the only opiate addicts at all likely to commit desperate and violent crimes to procure money for drugs, or to seize drugs.

The third stage is the "stable addict," who takes a regular dosage, usually has an adequate supply on hand to last him over periods when he may not be in contact with his source of drugs, and generally has several alternative sources. Such an individual is likely to spend from $50 to $200 a week for his drugs, and the lethargic state which this use promotes impairs what legitimate income-earning ability he may have.[4]

Although some upper class persons, as well as musicians and entertainers, have enough legal income to support stable opiate addiction,

---

[3] Harold Finestone, "Cats, Kicks, and Color," *Social Problems*, vol. 5, No. 1 (July 1957), pp. 3–13.

[4] Sol Kobrin and Harold Finestone, "Opiate Addiction Among Adolescent Males in Chicago," unpublished paper presented at American Sociological Association meeting, 1953.

most stable addicts must also be professional criminals. Their crimes generally are nonviolent offenses, yielding small sums each time, but pursued regularly enough to support their habit. These offenses include shoplifting, stealing from parked cars ("car clouting" or "boosting"), picking pockets, pandering, and prostitution. The sale of narcotic drugs sometimes becomes a source of income for advanced addicts, who are able to buy the drugs in large quantities at relatively low prices; they then regain funds for further purchases by selling a portion at a profit to less advanced addicts. It is alleged that the "higher ups," the importers and wholesalers in the criminal distribution of drugs, generally are not addicts, but that at least two-thirds of the retailers, those who sell directly to users, are addicts themselves.

PART IV—PERSONALITY AND NARCOTICS USE

It is widely held that addicts are of a distinct personality type, usually described as inadequate, immature, passive, and dependent. Unfortunately, these are not precise terms, and the characteristics which they describe are matters of degree, in which different ranges shade into each other. Indeed, it is probable that both addict and all other human beings vary considerably in these traits. While the average addict may be more passive, inadequate, or immature than the average nonaddict, some addicts do not have these traits pronouncedly and they are found in many persons who are not addicts.

The psychiatrist, David P. Ausubel, classifies drug addiction into three main categories: primary, symptomatic, and reactive. Primary addiction, he claims, serves special functions for the inadequate personality and for some persons suffering from anxiety.

The inadequate personality, Ausubel advises, suffers from "motivation immaturity"; although they are adults, such persons have the motivational patterns of children. Specifically, he says:

> "The inadequate personality fails to conceive of himself as an independent adult and fails to identify with such normal adult goals as financial independence, stable employment, and the establishment of his own home and family. He is passive, dependent, unreliable, and unwilling to postpone immediate gratification of pleasurable impulses. He demonstrates no desire to persevere in the face of environmental difficulties, or to accept responsibilities which he finds distasteful. His preoccupation with a search for effortless pleasure represents both an inappropriate persistence of childhood motivations which he has not as yet outgrown and a regressive form of compensation for his inability to obtain satisfaction from adult goals.
>
> "But although he is by any criterion a highly inadequate and immature person he does not have sufficient self-critical ability to perceive himself as such. In fact, this blunting of his self-critical faculty is partly a defensive device which enables him to preserve a serene self-portrait and appraisal of his present circumstances and future prospects in the face of conditions that would produce overwhelming feelings of inadequacy in others. It also spares him the effort, the planning and the self-discipline that would be required for effecting sincere improvement." [1]

[1] Ausubel, *op. cit.*, p. 42.

According to Ausubel, three kinds of child-rearing during middle childhood and preadolescence impair the development of motivational maturity. These are: (1) The extremely *overprotecting* parent who deprives the child of an opportunity to act independently; (2) the extremely *underdominating* parent, who makes no demands on the child; (3) the extremely *overdominating* parent, who makes demands on the child so beyond the child's capacity, that the child abandons all effort to achieve these goals and seeks only escape from parent domination. Ausubel views the drug experience as adjustive for individuals with these three backgrounds because it reduces their aspirations for adult goals; they can feel superior, and sublimate their sex and hunger drives, by the minimum effort of injecting a needle. In the case of a motivationally mature individual, Ausubel claims, a drug experience simply reinforces normal aspirations at the same time that it impairs ability to pursue them, so it is unadapting, and is not maintained by such persons.[2]

Anxiety states and reactive depressions are relatively rare personality conditions associated with primary addiction, according to Ausubel. These conditions he finds in what might be called overmotivated persons; they are highly ambitious and persistently striving, in compensation for a lack of self-esteem, due to either parental rejection or to insincere parental acceptance. He notes that such persons overreact to difficulties which pose a further threat to their self-esteem and they always feel insecure, regardless of their achievements, because of their unrealistically high goals. These addicts are more common in hospitals than in prisons, since they usually have economic resources to support their habit. Addiction is adjustive for these addicts; it reduces their emotional response to stress situations, but other sources of stress reduction are available, such as rationalization and projection. They tend to use mild opiate doses only, and maintain responsible employment and other social obligations.[3]

In addition to these two forms of "primary addiction," Ausubel distinguishes "symptomatic addiction" as a "nonspecific symptom in aggressive antisocial psychopaths." These individuals have a history of delinquency from an early age, and drugs have no adjustive value for them except as one more means of expressing contempt for society. They are atyptical addicts.[4]

"Reactive addiction" is the third major classification set forth by Ausubel. This is seen as a transitory condition of adolescence, usually a group expression of independence from adults. Such users generally do not develop physiological dependence, he claims, and do

[2] *Ibid.*, p. 46.
[3] *Ibid.*, pp. 47–48.
[4] *Ibid.*, p. 49.

not persist in drug use. They are most frequent in slum areas, starting the use of drugs as a delinquent gang activity. Of course, all adolescent narcotics users are not reactive addicts; some may represent the beginning stage of the other forms that have been distinguished, reflecting the types of personalities which these other forms serve.[5]

The fact that there is much variation in terminology for the description of personality, and most of it is broad in meaning, explains why different psychiatrists often may employ terms other than those used by Ausubel to point out similar observations. For example, psychiatrists Donald Gerard and Conan Kornetsky, comparing 30 juvenile addicts with a control group of 30 nonaddicts in New York, reached a conclusion summarized by their project director, Chein:

> "There appears to exist among the juvenile addicts a pattern of symptoms which clinicians in various parts of the country continue to confirm: (1) dysphoria, *i.e.*, a characteristic mood verging on depression and involving feelings of futility and expectations of failure; (2) problems of sexual identification evidenced by manifest sexual psychopathology and/or difficulties in assuming a masculine role; and (3) disturbances of interpersonal relations, characterized by inability to enter prolonged, close, or friendly relationships with either peers or adults. Furthermore, addicts typically have a low tolerance of anxiety and frustration, and are eager to use 'props' and supports of any kind whenever available. . . .
>
> "In the broadest terms, the potential male addict may be described as suffering from a weak ego structure, weak superego functioning, and inadequate masculine identification. . . .
>
> "As to what we have called ego-damaging factors, almost all the 30 addicts came from families where there was a disturbed relationship between the parents as evidenced by separation, divorce, overt hostility, or lack of warmth and mutual interest. Furthermore, most of these parents either overindulged or harshly frustrated the boys as children. Most of the parents of our addicts had unrealistically low (though sometimes they had unrealistically high) ambitions for the boy. What they wanted for him as an adult was usually inappropriate to their objective family circumstances or the ability of the youngster.
>
> "In relation to factors we have considered as leading to inadequate superego functioning, we found that the addicts experienced very frequently, and much more often than the controls, cool or hostile parent figures, weak parent-child relationships, lack of clarity as to the way in which disciplinary policies were established, and vague or inconsistent parental standards for the boy.

---

[5] *Ibid.*, pp. 49–54.

> "In relation to the third personality characteristic, there were many things about the family background of the addicts that would interefere with the normal development of feelings of masculine identification. In almost half of the cases, the father figure was absent from the home during the early childhood period, and in many other cases when a father was present, he was cool or hostile in his attitude to the boy. The general pattern was of a weak relationship (the father having very little to do with his son), open hostility, or no relationship at all because of a broken home." [6]

It should be stressed that this view of the addict's personality and that by Ausubel are not incompatible. They represent different attempts to reduce to a few major categories a highly diverse assortment of people and behavior. Any classification of human personalities sacrifices some details in order to limit its description to the highlights, and different selections may reasonably be made for this purpose. Ausubel, of course, was attempting to classify virtually all narcotic addicts in his categories, while Gerard and Kornetsky were limiting themselves to juvenile addicts in New York. But the major features of what Ausubel calls inadequacy and what the New York study calls weak ego structure are essentially the same.

The fact that many persons with the types of personalities described do not become addicts, and that addicts are highly concentrated in the slum areas of our large cities, and in minority groups, suggests that more than personality is involved in the acquistion of a drug habit. However, the fact that most minority youth reared in the highest drug-rate neighborhoods do not become addicts also suggests that more than neighborhood conditions is involved. Apparently both neighborhod and personality influence complex selection processes, in which only certain segments of our population have much contact with opportunities or inducements for drug use, but only certain personalities in these segments of the population find the drugs particularly adjustive. Chein describes this selection process in the slum areas as follows:

> "In the adolescent state (roughly under the age of 18) the street culture favors "acting out" on a gang basis. Rumbles, fights, hell-raising, competitive sports are an appropriate expression for this age. Even if the gang includes a large proportion of anxious, inadequately functioning boys (of the type we would consider prone to drug use), the activities of the gang offer a measure of shared status, a measure of security, and a sense of belonging. The boys do not have to face life alone—the group protects them. Escape into drugs is not necessary as yet.

---

[6] Chein, *loc. cit.*, pp. 56–57.

"But as the group grows older, two things happen. Sports, hell-raising, and gang fights become 'kid stuff' and are given up. In the normal course of events, the youthful preoccupations are replaced by more individual concerns about work, future, a 'steady' girl, and so on. If most of the gang members are healthy enough to face these new personal needs and engage in the new activities appropriate for their age, the availability of drugs will not attract their interest.

"But for those gang members who are too disturbed emotionally to face the future as adults, the passing of adolescent hell-raising leaves emptiness, boredom, apathy, and restless anxiety. In a gang where there are many such disturbed members, the lone user will soon find companions, and cliques of users will grow quickly. Enmeshed in the pattern of activities revolving around the purchase, sale, and use of drugs and the delinquent efforts to get money to meet the exorbitant cost of heroin, the young users can comfortably forget about girls, careers, status, and recognition in the society at large. Their sexual drive is diminished, they maintain a sense of belonging in the limited world of the addict, they remain children forever." [7]

Cloward and Ohlin suggest that young drug addicts commonly are "double failures." They have a history of failure in conventional pursuits, school and employment, and failure to achieve success and status in groups pursuing delinquency and crime.[8] It is conceivable that such failures would include a disproportionate number of inadequate personalities, as well as a disproportionate number of persons handicapped by membership in minority groups. However, still another possibility is that part of the reported personality inadequacy or weak ego is an erroneous diagnosis. Such errors could reflect a bias of successful middle class observers, especially those not from minority groups, who may fail to appreciate the normal differences between their own past career outlook and the goals and expectations of most slum and minority youth. Large-scale research on various aspects of delinquency now underway in several cities may result in more precise knowledge in this area.

---

[7] Chein, *op. cit.*, pp. 54–55.

[8] Richard A. Cloward and Lloyd E. Ohlin, *Delinquency and Opportunity*, New York: Free Press of Glencoe, 1960, pp. 178–186. A comparison by Roebuck of Negro narcotic prisoners with other Negro prisoners suggests that the narcotics users exceed the others in conventional aspirations; their early family, school and community backgrounds and adjustments were superior to those of non-addicts. Julian B. Roebuck "The Negro Drug Addict as an Offender Type," *Journal of Criminal Law, Criminology, and Police Science*, vol. 53, No. 1 (March 1962), pp. 36–43. This higher aspiration may augment their sense of failure, a process which social psychologists call "relative deprivation."

PART V—THE SUPPRESSION OF NARCOTICS

The earliest American law regulating the handling of narcotics consists of the 1912 Hague international treaty on control of the opium trade, to which the United States was a signatory. There have been several subsequent international agreements in this area. Americans, since President Theodore Roosevelt, have been prominent in the leadership of these world efforts to control the movement of drugs between nations. Later we shall discuss the effectiveness of these measures.

The basic domestic law is the Harrison Act of 1914. It placed an excise tax on transactions in narcotics and, therefore, required that detailed records be kept of all transfers of these drugs. The law specifically exempts physicians, dentists, or veterinarians from penalties for dispensing the drugs to patients in the course of their professional practice. There is no mention of addiction.

Before the Harrison Act, narcotics could be purchased in any pharmacy, through numerous mail order stores, and even in grocery stores. No prescription was required. Laudanum, an opiate with pain-relieving qualities, was widely used by housewives. The social movement which resulted in passage of the Harrison Act involved the same leadership and organizations that achieved passage of the Prohibition Amendment and the Women's Suffrage Amendment some years later. The most active supporters of these measures acted through major Protestant denominations and organizations such as the Women's Christian Temperance Union.

Since the Harrison Act is a tax measure, its administration was assigned to the Treasury Department, which established the Narcotics Bureau. Early in the 1920's, Treasury publications advised physicians when to prescribe drugs and when not to prescribe them. In 1925, a Spokane physician, Dr. Charles O. Linder, gave four tablets of drugs to an addict who was a Government informer, and the Federal District Court convicted Linder of violating the Harrison Act. The conviction cost him his license for two years, and $30,000, before the lower court decision was set aside by the Supreme Court in a ruling which clarified some restrictions on physicians in earlier decisions.

Two important features of the Linder decision were: (a) the explicit statement that addiction is a disease; (b) the explicit statement that physicians can legally, if in good faith, give addicts small dosages

of narcotic drugs to relieve withdrawal symptoms.[1] However, Narcotics Bureau literature to physicians emphasizes their risk of arrest in treating addicts, consequently, few care to deal with addicts outside of public hospitals specifically established for this purpose. The principal hospitals of this type are the U.S. Public Health Service Hospitals at Lexington, Kentucky, and Fort Worth, Texas, and New York City hospitals at Bellevue and Riverside.

In 1937, a special Marihuana Tax Act was passed regulating transactions in marihuana much as the Harrison Act regulates the transfer of opiates. Since marihuana has little or no legitimate use in medicine, the registration and taxation features of this act rarely are used to control legitimate transfers, but the penalty features are available for the prosecution of illegitimate marihuana sales.

In reaction to the increased prominence of narcotics usage, and the change in its distribution in the population during the 1940's, the Boggs Act was passed by Congress in 1951. This law prescribed a definite sentence, fixed by the court within a 2- to 5-year range, for possession of narcotics on first conviction. It stipulated a sentence range of 5–10 years on second conviction and 10–20 years on a third conviction. Also, this Act denied parole to those convicted under it.

In 1955, the House of Delegates of the American Bar Association requested a review of narcotics legislation by the Senate Judiciary Committee. A subcommittee headed by Senator Price Daniel of Texas held prominent public hearings at which various police and sheriff officials called for more severe penalties. The resultant Federal Narcotic Control Act of 1956 maintained the penalties for possession in the previous Act, but increased the maximum possible sentence on a third conviction to 40 years. For sale or transfer, it specified a definite sentence within a 2- to 10-year range on first conviction, 5–20 years on second conviction, and 10–40 years on third or subsequent convictions. All of these sentences are without parole. For the sale of heroin to a person under 18 years of age, Federal courts are authorized to impose a life sentence, and Federal juries may impose a death sentence. To facilitate enforcement, Customs and Narcotics Bureau officers are permitted to make arrests without a warrant, on belief that a drug-law offense has been committed. In addition, a 2-year penalty is imposed for using communication facilities to arrange traffic in narcotics.

---

[1] *Linder* v. *United States*, 268 U.S. 5, *45* Sup. Ct. *446* (1925). For a detailed description of the relationship of the Linder case to earlier decisions of the U.S. Supreme Court and its implication for treatment of the addict, see "Narcotics Law Violations, A Policy Statement," *Advisory Council of Judges of the National Council on Crime and Delinquency*, National Council on Crime and Delinquency, May 1964.

A standard draft for a State law, issued by the Bureau of Narcotics and known as the Uniform Narcotics Drug Act, has been adopted by 46 States, the District of Columbia, and Puerto Rico. Four States—California, Massachusetts, Pennsylvania, and New Hampshire—drafted their own narcotics control legislation, but all except the New Hampshire law are considered comparable to the Uniform Act. The latter left blank the sections on penalties, but most States have penalties similar to those of the Federal Act, although some are in greater detail. In Illinois, for example, penalties for soliciting or encouraging a minor to violate the Drug Act include indeterminate sentences with minimum and maximum fixed with a range of 2–5 years. The range is 1–10 years for agreeing to sell narcotics, and increases on the second offense to a 10–year minimum and no maximum. The Illinois penalty for illegal purchase or possession is an indeterminate sentence, with 2- to 10-year limits, for the first offense, and 5 years to life for subsequent offenses. Probation or suspension are forbidden for the subsequent offender. For selling or dispensing, the penalty range is from 10 years to life on first offense, and mandatory life on subsequent offenses, with no suspension or probation even on first offense. In addition, Illinois provides a jail sentence for a definite term, ranging from 90 days to a year, for unlawfully using or being addicted to narcotics.[2] Needle scars are defined as *prima facie* evidence of use. Probation is permitted for this offense only if part of the probation is served in jail.

Other provisions in Illinois and many other States authorize synthetic opiate (Nalline) tests for any person arrested on a drug charge, but only with his written consent, and permit such consent to be a condition of probation or parole for anyone with a record of a drug offense. These tests will be discussed later in this chapter. The arrested addict who can be convicted for one of the several separate offenses distinguished in the narcotics legislation generally can be convicted for other ones also, so the prosecutor can threaten to indict on the charge with the most severe penalty, in order to induce a plea of guilty to a lesser charge.[3]

---

[2] This act has been held unconstitutional insofar as it subjects persons to arrest and imprisonment for the crime of being an addict *per se*. *People* v. *Davis*, 27 Ill. 2d 57, 188 N.W. 2d 225 (1963). See the decision of *Robinson* v. *California* below.

[3] All detailed articles summarizing narcotics legislation which we have encountered are highly evaluative in their presentation. For a summary with favorable evaluation see Maurer and Vogel, *op. cit.*, chap. 7. For detailed but derogatory reviews, see Rufus King, "Narcotic Drug Laws and Enforcement Policies," *Law and Contemporary Problems*, vol. 22, No. 1 (Winter 1957), pp. 113–131; Donald J. Cantor, "The Criminal Law and the Narcotics Problem," *Journal of Criminal Law, Criminology, and Police Science*, vol. 51, No. 5 (January–February 1961), pp. 512–527; Alfred R. Lindesmith, "Federal Law and Drug Addiction," *Social Problems*, vol. 7, No. 1 (Summer 1959), pp. 48–57.

Difficulties in Suppressing Narcotic Traffic

There can be no doubt that efforts to enforce the Harrison Act and State regulations have made narcotic drugs harder to procure for non-medical use. Before 1914, the import, cultivation, and processing of narcotic drugs were legal, but now drugs must be smuggled, and they must be processed secretly. Formerly, places for the retail purchase of drugs were readily accessible to any prospective customer, prices were not beyond ordinary means, and there was no risk of punishment involved. Now, a would-be purchaser must know how to contact and gain the confidence of illegal peddlers, the drugs are exorbitantly expensive, and he risks arrest, fine, and imprisonment in procuring them. Perhaps the fact that drug purchase means classifying oneself as criminal is the major deterrent to their use today.

Nevertheless, a limit seems to exist in the extent to which the supply of narcotic drugs can be cut off from those who are able and willing to purchase them through illegal channels. When profits are high and the crime is feasible, some persons will always be attracted to it. Four of the major problems in trying to control the narcotics traffic are the compactness of the product, the financial profit in this trade, the incompleteness of international controls, and the fact that the user does not consider himself a victim.

As indicated earlier, heroin usually is used by addicts in a mixture of only 1 or 2 percent narcotic, the remainder being an inert substance, generally milk sugar. Pure heroin is a white powder which is extremely valuable because of the large number of addicts that a small amount can supply. It is estimated that heroin purchased for $1,000 in Italy or the Middle East is sold for $300,000 retail in the United States.[4] These fantastic profits motivate the underworld to take extreme risks to smuggle it into the United States, and they have international syndicates for this purpose.

The compactness of these drugs make smugglers relatively hard to detect. A package of a few ounces, salable for several thousand dollars by the underworld, may be no larger than a pack of cigarettes. In order to search incoming traffic to the United States so thoroughly that even narcotics in amounts of 1 pound or 2 would be discovered would require a disturbance of international travel and shipping to an extent that the public probably would not tolerate.

Interviews with juvenile drug addicts in California Youth Authority institutions indicate that many of them make a regular practice of crossing the Mexican border with as little as $30, with which they readily purchase drugs in the border cities at about half their cost

[4] Cantor, *op. cit.*, p. 520; Ausubel, *op. cit.*, p. 70.

in Los Angeles. They use part and sell the remainder on their return.[5] If juveniles can do this, adult criminals obviously would find little difficulty in concealing many pounds of heroin in an automobile, if it is given no more than the perfunctory search which prevails at the border. Intercepting smuggled heroin, therefore, requires that the police have some special reasons for suspecting a border crosser, either through a tip from an informer or from his dress or manner. The latter clues are likely only to reveal the small and inexperienced operators.

Although most countries of the Western World are signatories of international agreements to regulate the traffic of opiates, some countries are not. Those with Communist governments, notably China, and Cuba under Castro, do not feel themselves obliged by agreements of the preceding regimes. Indeed, they are motivated to sell as much narcotics as they can in the West, both for a supply of dollars and to reduce the efficiency of non-Communist countries. Also, in many other underdeveloped areas, notably Iran and other lands of the Middle East, opium has long been a principal crop. Its regulation by the government reputedly is corrupted by feudal landholders. Apparently large amounts of their production is exported illegally, in addition to that which they ship for medical purposes under the standard international registration and control.[6] One of the strongest signs that some limit has been reached in the extent to which we are likely to eliminate traffic in illegal drugs in the United States is the fact that the underworld prices in major city areas allegedly remain relatively stable. Particularly in California, it has been reported that there is a constant flow of drugs to meet the demands of the profitable market, with small independent importers expanding when large distributors are apprehended.[7] It appears that we are sharply limited to the degree that we can control drug distribution in Mexico, and to restrict border crossing, enough to prevent illegal import, would require at the same time the disturbance of significant American and

---

[5] Stuart Adams and Dorothy Zietz, *Patterns of Narcotic Involvement: The Autobiographies of Five Juvenile Offenders*, Sacramento: California Youth Authority Research Report No. 28, February 1962; "Commuting to the Border: Narcotics Case Profile," *California Youth Authority Quarterly*, vol. 15, No. 1 (Spring 1962), pp. 3–9.

[6] Bertil A. Renborg, "International Control of Narcotics," *Law and Contemporary Problems*, vol. 22, No. 1 (Winter 1957), pp. 86–112; Cantor, *op. cit.*, pp. 519–522.

[7] "Atty. Gen. Stanley Mosk says narcotics smuggling has reached the point where marihuana is being shipped into Southern California in half-ton lots and heroin in 2-pound packages. Mosk, speaking at the California Veterans of Foreign Wars convention, said there is so much marihuana and heroin on the Southern California market that prices have been forced down. . . . Mosk said the situation is demoralizing to law enforcement, because it indicates almost unlimited supplies." From Associated Press Report, San Diego, June 21, 1960.

Mexican business and tourist interest which affect many more people than the drug traffic.

A final problem in prevention is that the participants in drug crimes include no one who considers himself a victim. As with other illegal service crimes, there are no voluntary complainants to report most of these offenses. It is because of this that the police need extreme methods if they are to achieve arrests which will result in convictions; they generally must entrap the offenders by using paid informers, who act as sellers or customers. Known addicts are converted to informers through payment by the police, through threat of arrest and of a report of noncooperation to the court, and sometimes, through being allowed to keep some drugs they purchase illegally, or through promise of immunity or of favorable recommendation to the court.

These morally compromising devices to motivate an informer, of course, increase the possibility that innocent persons will be arrested and even convicted, although this probably happens rarely.

Suppression and Medical Treatment in the Community

An approach to the control of drug usage different from that employed in the United States is to consider addiction purely an illness, rather than a crime, and an illness seldom requiring institutionalization. This implies no penalties for addiction, but public responsibility to make medical treatment more readily available for this disease. This conception may still imply suppression of illegal traffic in drugs to reduce spread of the disease but it also implies a change in the conditions which create demand for illegal narcotic traffic. In short, this approach sees addiction primarily as a public health problem, and deals with it in the same fashion that we handle other public health problems.

This is the method employed in Britain, and in many other countries. Persons who are addicts must be registered with a central office by a physician, and they are required to go to him for treatment. The physician may give the addicts the drug to which they are addicted, but he is supposed to try to taper their dosage down and to try to cure them. The patients pay normal medical fees for the service and for the drug, rather than the exorbitant prices demanded by illegal dealers. Since the introduction of socialized medicine in Britain, this service has become particularly cheap for the addict, since there is only one nominal price for any type of medication, amounting to less than half a dollar.[8]

---

[8] Alfred R. Lindesmith, "The British System of Narcotics Control," *Law and Contemporary Problems*, vol. 22, No. 1 (Winter 1957), pp. 138–154; Edwin M. Schur, "British Narcotics Policies," *Journal of Criminal Law, Criminology, and Police Science*, vol. 51, No. 6 (March-April 1961), pp. 619–629. See also the statement of the Advisory Council of Judges of the National Council on Crime and Delinquency, *op. cit.*

In the United States, the medical approach was employed in clinics for addicts which were opened in the early 1920's. These clinics were soon closed at the recommendation of physicians and State and local governments since the clinics failed to reduce the rate of addiction or criminal activity associated with addiction. There were conflicting opinions as to the effectiveness of these clinics. The Narcotics Bureau contends they were a failure; however, some writers claim that they were relatively successful with many cases and were never given an adequate chance to develop and improve by experience.[9]

The argument for the British system of assigning addicts to individual physicians emphasizes the fact that there are less than 400 registered addicts among the 60 million people in Great Britain, as compared to estimates ranging from 60,000 to 200,000 addicts among the 200 million people in the United States. The dimension of our addiction problem, its concentration in lower income youth and minority groups, and the busy practice which most American physicians already have, might make it difficult to adopt the British system without modification. Probably medical treatment of addicts in the United States would require establishment of clinics in those neighborhoods where addicts are most concentrated. Addicts elsewhere, or those with more financial resources, probably could be treated by physicians in private practice if this were legal.

Under the British system, the transfer of narcotic drugs is closely regulated, and illegal transactions in narcotics are punished. Indeed, British law and our Harrison Act are highly similar. This justifies some assertions that the British system is like the American system; however, there remains a sharp distinction. Only in the United States are official administrative efforts made to prohibit the giving of opiates by a physician in the community for the purpose of relieving or preventing an addict's suffering from withdrawal effects.

Critics of proposals for legal administration of drugs to noninstitutionalized addicts in the United States argue that addicts will never be satisfied with a medically prescribed dosage. They suggest that the addicts will still seek additional drugs from illegal channels, and that dealers in illegal drugs will continue to introduce many youths to addiction. Clinics cannot serve merely for the treatment of those persons who are addicted at the time the clinics are established. Efforts must be made to prevent continuance of an illegal drug market for those addicted afterwards. Despite occasional citation of sensational cases, illegal drug trade does not appear to have ever become pronounced in Great Britain, where all new addicts are referred to physicians, and the number of addicts has not markedly increased. While handicapped by their addiction, these addicts are able to be self-sup-

[9] Hubert S. Howe, "An Alternative Solution to the Narcotics Problem," *Law and Contemporary Problems*, vol. 22, No. 1 (Winter 1957), pp. 132–137.

porting and probably are not as disturbing to others in the community or to themselves as are chronic alcoholics.

Much of the controversy on this problem reflects differences in moral philosophy. Proponents of medical treatment consider addiction a private matter and object to its punishment as a crime, particularly if the user does not inflict his ailment on others and conforms to regulations on procuring his drugs through standard medical channels. They have sometimes compared the addict with a diabetic, who can lead a useful life if allowed to take regular shots of insulin. Critics of this position view addicts personally as morally evil, and as sources of moral contamination to others in the community.

The extent to which American drug usage now is associated with criminality probably accounts for the moral opprobrium directed towards narcotics. A further argument against purely medical treatment of drug addiction is one which is applicable to the legalization of every vice, including alcohol, gambling, and prostitution. This is simply that vices seem to be pursued by more people and more frequently, when they are readily visible, accessible, cheap and respectable, than when they are hidden, remote, expensive, or disreputable. Clinics conveniently located and open to all who request service might encourage some new users, just as corner taverns and liquor stores attract patronage which would not be drawn to a remote and illegal bootlegger. This may mean only that clinics can have greatest utility in reducing the dimensions of the drug problem only if a sound medical regulation of their service is achieved.

PART VI—ALTERNATIVE TREATMENTS FOR NARCOTICS USE

In discussing alternative modes of treatment for those involved with narcotics, it is necessary to delineate the concern of this particular section. The emphasis here is on the treatment of those persons who personally use narcotics rather than those who are involved in supplying them. Since a number of users also "push" narcotics, primarily to support their own habit, the various treatments reviewed here would have applicability to them. However, the problem of the supplier, as such, who may or may not use narcotics incidentally, involves other treatment and control strategies which will not be discussed here. The purpose of this publication is primarily to review various attempts to alter the behavior of the user of narcotics.

The most widely employed method of treating narcotics use in the United States are: (1) imprisonment; (2) hospitalization (with medical and psychological services); (3) institutional counseling; (4) community surveillance (including compulsory tests for drug use); (5) casework in the community; (6) mutual aid organizations of ex-addicts.

Each of these treatments, of course, often actually includes various combinations of these methods, but for convenience of analysis, each will be discussed as totally separate classifications here.

Imprisonment

Most statistical data show that the postrelease violation rate of persons committed to prison for narcotics offenses usually has not been exceptionally high compared to that of those committed for other types of offenses, but this varies from one jurisdiction to the next.

Consistent with the inadequacy of personality ascribed to them by Ausubel, narcotics offenders are reported to be generally highly conforming prisoners. In Federal prisons, there has been no difficulty in placing many of these men on minimum security assignments remarkably early, despite the length of their sentences and their ineligibility for parole. Apparently the prison situation, where their days are structured and their lives secure, is not such a deprivation for them as it is for other offenders. There are, of course, exceptions to this pattern, reflecting perhaps the personalities other than passive dependents which Ausubel associated with addiction.

Imprisonment, of course, may not be very constructive if it does not involve parole. Eliminating parole removes a major incentive to

change the length of confinement by self-improvement in prison. It also denies the State the right to provide surveillance, supervision, or assistance to the narcotic offender after he is released.

Even when the best modern prisons provide as much therapy as is available in many public hospitals, an additional argument against imprisonment is the notion that addiction is a disease, rather than a crime. This implies that narcotics users should be confined only as long as their medical needs warrant. Such an approach is especially in conflict with the Federal sentencing policy for narcotics offenses, which requires long confinement and offers no prospect of parole. This clearly contradicts the basic medical principles of individual treatment and release based on medical diagnosis.

Mr. James V. Bennett, formerly Director of the Federal Bureau of Prisons, has asserted: ". . . the American narcotics statutes . . . in their savagely indiscriminate treatment of violators, will someday be equated with the Salem witch trials of colonial America." [1]

The view that narcotic addiction is essentially a medical rather than a criminal problem was given some emphasis by a holding of the U.S. Supreme Court in 1962 in the case of *Robinson* v. *California*.[2] In this case, the U.S. Supreme Court struck down a section of a California statute which imposed a criminal status and a penal sanction on one who was addicted from the use of narcotics. The critical point in the decision is that California had interpreted their law as making unlawful the "status" or "condition" of addiction without proof of actual use of narcotics or other accompanying misconduct (*e.g.*, possession of narcotics) within the State's jurisdiction.

Justice Stewart, speaking for a majority of the court, said, "We deal with a statute which makes the 'status' of narcotic addiction a criminal offense, for which the offender may be prosecuted 'at any time before he reforms.' " The Court found this to be a cruel and unusual punishment and thus a violation of the Eighth Amendment of the U.S. Constitution. However, the court went on to indicate, "A State might impose criminal sanctions, for example, against the unauthorized manufacture, prescription, sale, purchase or possession of narcotics within its border. . . . The State might establish a program of compulsory treatment for those addicted to narcotics . . . . And penal sanction might be imposed for failure to comply with the established compulsory treatment procedures." Thus, while the condition of addiction itself cannot be subject to criminal prosecution, the State can continue to prosecute for the many actions incident to addiction. It appears, therefore, that penal sanctions directed toward these inci-

---

[1] In Bennett's review of John V. Barry, *Alexander Maconochie of Norfolk Island*, published in *American Journal of Correction*, vol. 22, No. 5 (September–October 1960), pp. 38–39.

[2] *Robinson* v. *California*, 370 U.S. (1962), rehearing denied, 371 U.S. 905 (1962).

dental actions will continue to cause many drug addicts to be sentenced to prison. Of course, whatever the ultimate legal decision might be, an optimum prison program, with flexible parole prospects, can have a number of the features of a hospital program for addicts.

Hospitalization

California, in 1961, and New York, the following year, passed laws providing for civil commitment of drug addicts to mental hospitals. Actually, most States could probably make such commitments under appropriate interpretation of existing laws, but this seldom is done. The New York laws permit: (a) voluntary commitment of an addict to a hospital, on his own initiative or on that of next of kin, with a court procedure like that of mental commitment, and a provision that once committed the addict must stay for the duration of treatment or up to a year; (b) voluntary commitment of an arrested narcotic addict with consent of court, regardless of crime for which arrested, to a mental hospital having proper safeguards, with stay of prosecution until treatment in the hospital and in outpatient aftercare is completed. In the latter case, criminal charges are dismissed if the medical program is completed to the satisfaction of the supervising physicians.[3] Several proposals for Federal legislation of this type have been submitted to Congress.[4]

Commitment to U.S. Public Health Service and other hospitals for treatment of drug use can be entirely voluntary, can be voluntary as a fulfillment of a condition of probation, or can be on sentence to Federal imprisonment. Only in the latter two types of arrangement is there certainty that the patient will remain until the physicians consider him ready for release, which generally is only after a minimum of 6 months' confinement. Because of their sentenced cases, the two Federal hospitals, at Lexington and Fort Worth, are constructed like medium security prisons.

Hospitals are notably successful in dealing with withdrawal disturbances and in relieving other physical ailments of the addicts. Patients suffering withdrawal symptoms on arrival generally are given methadone, a synthetic drug related to the opiates, which relieves opiate withdrawal symptoms, but does not have withdrawal effects of its own as disturbing as those of the opiates. Thus, the patient's body shifts from opiate to methadone intake, and the latter is gradually terminated.

---

[3] Richard H. Kuh, "Civil Commitment for Narcotic Addicts," *Federal Probation*, vol. 27, No. 2 (June 1963), pp. 21–23.

[4] Emanuel Celler, "An Alternative Proposal for Dealing with Drug Addiction," *Federal Probation*, vol. 27, No. 2 (June 1963), pp. 24–26. The Advisory Council of Judges of the National Council on Crime and Delinquency has taken a position against any type of commitment of drug addicts, *op. cit.*

In addition to this medical treatment, most hospitals for addicts have a higher ratio of psychological and social work staff to patients than are found in prisons. This staff provides examinations for all cases, and special counseling programs for those individuals who seem most likely to profit from them. Some of these hospitals also have active chapters of Narcotics Anonymous or Addicts Anonymous, which are discussed below, in which patients are encouraged to participate. These may place them in contact with chapters on the outside. In the opinon of many, the major limitation of hospital treatment, especially at hospitals distant from the addict's home, is the inability to continue counseling after the patient returns to a nonhospital environment.

Records on the outcome of hospitalization in treating addiction are grossly inadequate. Only in 1962, with the establishment of a Sociology Section at the Addiction Research Center at Lexington, Kentucky, were that hospital's intake records punched on statistical tabulation cards and routine statistical collection initiated. In addition, field studies of ex-patients are underway. Three significant past studies of patients released from the Federal hospital at Lexington are especially interesting because of their contrasting results, as follows:

1. A study of all 4,766 male patients discharged during the calendar years 1936 through 1940, using FBI fingerprint records, hospital records and correspondence for follow-up information, found that 25 percent of those for whom postrelease information was procured had been abstinent, 43 percent were readmitted to institutions, 7 percent were dead, and the remaining quarter had intermittent relapses. However, this percentage is only applied to the 60 percent of the sample for whom follow-up information could be procured. There is reason to believe that *nonrelapse* was more common in the 40 percent who could not be traced than in those studied, since most of the tracing resulted from the releasee having further contact with the hospital or with police or correctional authorities.[5]

2. In a follow-up of 1,912 New York addicts discharged from the Lexington, Kentucky, hospital between July 1952 and December 1955, actual contact was made with most of the releasees whose records could not be determined from official files. The study concluded that 90 percent of the hospital's releasees from

[5] M. J. Pescor, "Follow-Up Study of Treated Narcotic Addicts," *Public Health Reports*, Supplement No. 170, Washington, D.C.: U.S. Government Printing Office, 1943.

New York were readdicted in 6 months, 3 percent used narcotics irregularly, and only 7 percent were abstinent.[6]

3. Follow-up interviews and investigations, including tests, of a sample of 285 individuals committed to the Federal hospital at Lexington from within the State of Kentucky between May 1935 and December 1959, have been initiated by the Sociology Section of the hospital's Research Center. Preliminary findings suggest that of those still alive, about 75 percent are abstinent now, and the remainder still are addicted, but about one-fifth of those now abstinent admitted a previous relapse.[7]

The foregoing suggests that addicts are most likely to relapse if they return to an area where they previously used drugs, or where drug use is concentrated, and if they procured the drugs from criminal rather than from other sources. These may be useful clues for evaluating the parole prospects of persons with a history of addiction.

About 40 percent of Federal narcotics hospital admissions now are readmissions. However, it is noteworthy that many readmission cases remained abstinent for several years between relapses. Some ultimately become abstinent for a lifetime, after having several hospitalizations. In many of these, and other cases, the hospital certainly may have been valuable as a refuge from the circumstances of addiction, as a place for humane detoxification, and possibly, as a locale for remobilization of personality resources, counseling, and planning for more successful efforts at abstinence in the future.

A systematic study of a number of addicts who went through a cycle of cure and relapse indicates that they develop guilt feelings when using drugs and high expectations about life as an abstainer, leading to the decision to take a cure. However, their aspirations regarding favorable relationships and self-conception as an abstainer are not realized, so they subsequently are attracted back to the social world of addicts, where they have more gratifying social relationships.[8] Possibly the tapering off of drug arrests after age 40 indicates the older person's final maladjustment in younger addict worlds. This cycle suggests the importance of social factors in both treatment and prevention of addiction.

Institutional Group Counseling

A number of States, notably California, have special counseling programs for drug addicts in institutions. Under legislation in Cal-

---

[6] G. Halsey Hunt and Maurice E. Odoroff, "Follow-Up Study of Narcotic Drug Addicts after Hospitalization," *Public Health Reports*, vol. 77, No. 1 (January 1962), pp. 41–54.

[7] John A. O'Donnell, "A Post-Hospital Study of Kentucky Addicts," *Journal of the Kentucky State Medical Association* (July 1963), pp. 573–77, 604.

[8] Marsh Ray, "The Cycle of Abstinence and Relapse Among Heroin Addicts," *Social Problems*, vol. 9, No. 2 (Fall 1961), pp. 132–140.

ifornia, parolees with a history of narcotics use who are found to be relapsing to drugs but are not yet known to have committed serious offenses, may be returned to prison for a 90-day counseling program. They then resume parole, without formally being declared violators. This program is operated at Chino and San Quentin prisons, with the inmates involved separated from the rest of the prison population. It is conducted in conjunction with a community surveillance and testing program, to be described in the next section.

In the Chino program, all returnees participate in a single counseling session for over an hour each morning, and they have small group sessions of similar duration in the afternoon. Women prisoners returned under the same program are transported to Chino daily from the nearby State prison for women, to participate in the groups with the men. Clinical psychologists and social workers, as well as some custodial staffs and visiting parole officers, sit with the groups which are operated under nondirective techniques.

A much more structured content in counseling was reported in New York, where the "psychodrama" technique was employed in work with addicts at Rikers Island Penitentiary and at Riverside Hospital. In this procedure, after semidirected discussion brings out the addict's problems in various social relationships, special manipulations are introduced to make him more aware of the viewpoints of the others in these relationships. In the "role reversal" technique, one addict plays the role of another person, such as the mother, about whom a given addict has perhaps complained, or the addict who is troubled with relationships with his mother plays his mother, while someone else plays him. In the "double" technique, one addict stands behind a subject addict, and tries to express the feelings which he believes the subject is experiencing but cannot express well. A third technique, the "soliloquy," simply is to get the subject addict to say whatever comes into his mind, for an extended period, before the counseling group. In the "mirror" technique which is something like the double, the addict assisting the subject to express himself actually imitates what he considers are relevant features of the subject's behavior and expression. All these devices are directed at stimulating insight and behavioral reeducation. It has been suggested that not only the participant who is subjected to analysis at a given moment, but all participants in these dramas may gain insight, for all have similar problems.[9]

Group counseling programs in an institution are subject to the same major problems which confront hospitalization alone as a treatment for addicts. The counseling is done in a situation which is highly

[9] Lewis Yablonsky, "Group Psychotherapy and Psychodrama for Drug Addicts," *National Probation and Parole Association Journal*, vol. 5, No. 1 (January 1959), pp. 63–70.

protected and which becomes increasingly remote when the addict returns to the pressures of his environment.

Community Surveillance and Testing

Initial identification of addicts comes mainly from informers or is incidental to their arrest on other grounds. However, once a person's prior narcotics involvement is known, he can be watched, particularly if he is on parole or probation and, therefore, is required to report and is restricted in his freedom of movement. Nevertheless, establishing with certainty whether such persons currently are using drugs poses special problems. Fresh needle marks have been considered acceptable evidence in court. Analysis of urine provides highly conclusive evidence on the use of narcotics, but the tests require about 6 hours of laboratory processing. In recent years, however, a new adjunct to surveillance has been discovered—the so-called Nalline tests.

Nalline (also called Nallorphine, or by still more complex chemical names) is a drug of a type properly called an antinarcotic. It is related to the opiates in such a way that if a person has opiates in his body, an injection of Nalline will give him withdrawal symptoms. Only enough Nalline is injected for minimum withdrawal effect to occur, namely, the dilation of the eye pupils. The pupils are first measured under controlled light conditions, Nalline is then injected into the arm, and an eye pupil measurement is repeated in 20 to 30 minutes. If the person tested has not been using opiates, his eye pupils will now be measurably smaller; if he has been using opiates, the pupils will be unchanged or enlarged, depending on the amount of opiates he has been using and on individual variations in extent of reaction. While some testings are inconclusive, it is felt that if a person persists in using narcotics and if testing is frequent, this use will be evident in a subsequent test. Errors are deliberately kept in the direction of overlooking probably slight drug usage, so that any conclusion that opiates are being used is highly dependable and has been accepted in court as legal evidence.[10]

The Nalline test has been administered on a scheduled and on a surprise basis in California to thousands of parolees, probationers, and arrestees who have histories of narcotics usage or are suspected of drug use. Persons whose test results are positive are immediately placed in custody. One indicator of the effectiveness of frequent test administration in changing drug use patterns is that the number of parolees with positive test results declines steadily when the testing practice becomes established, from over a fifth to less than 1 percent.

---

[10] *People* v. *Williams*, 164 C.A. 2d Supp. 858, 331 P. 2d 251 (1958). See also: Thorvald T. Brown, "Narcotics and Nalline: Six Years of Testing," *Federal Probation*, vol. 27, No. 2 (June 1963), pp. 27–32; Charles T. Hurley, "Anti-Narcotic Testing: A Physician's Point of View," *Ibid.*, pp. 32–38.

Some persons connected with the Nalline testing program in California have suggested in conversation that the test is a "chemical conscience." The former addict on parole or probation with a regular testing program knows that if he resumes drug use he will be caught. This pressure, it is claimed, leads him to forsake temptations to return to drug user circles. The experience of success at a legitimate way of life, and the new social contacts made there, tend to end his attraction to drugs. It has been claimed by some test advocates that some former addicts gain self-confidence from the test's objective demonstration and that they have been successful in abstaining from drugs, something no one had believed they could do.

It has been alleged, however, that addicts may time their drug use so as to avoid detection at any regular test time, and that they may reduce their drug intake sufficiently to have some success in masking their usage when given a test with as little as 24 to 48 hours' notice. It also has been alleged that the tests encourage them to take nonopiate narcotics. These tactics, of course, might make their drug use less disabling than a more heavy and persistent opiate habit would be. The fact that Nalline test centers for parolees promote contact among addicts, who fraternize in the waiting rooms, is another minor criticism of these testing programs. Finally, there has been some objection to an involuntary Nalline test as an infringement on an individual's right to privacy, his rights against self-incrimination, and his personal dignity. Test advocates contend that these charges may have some strength for arrestees, but they argue that parolees or probationers have a weaker case on this point because of their agreement to cooperate in this program as a condition of their release. Time alone will tell if these distinctions will be supported by judicial findings.

The California Narcotics Treatment-Control Project, established late in 1959 in the Los Angeles and San Francisco areas, provides the following features for the parole supervision of persons with a history of opiate use:

(1) They are placed under specially trained parole agents, dealing only with addicts.

(2) These agents have caseloads of only 30, as against the usual adult caseload of about 75.

(3) The parolees agree to receive at least one regularly scheduled Nalline test per week, and one surprise test per month (they are given less than 48 hours' notice on the latter).

(4) Those parolees found using drugs again are returned for 90 days to a special counseling center at a prison (described in the preceding section), but they are not declared parole violators.

(5) The initial administration of the project included a research design in which a randomly selected control group of these parolees was allowed to remain in regular-sized caseloads, but were still

given Nalline testing, and still another randomly selected control group was released to regular caseload supervision without testing.

Of the experimental narcotics program cases in the Los Angeles area, 65 percent were detected using narcotics again within an 18-month period, most of these within the first 6 months after release. In the control group with Nalline testing, 60 percent were found to be using drugs within 18 months, and in the control group without testing, only 47 percent were detected in drug use in this period. The experiment was considered successful and is being continued, on the assumption that the untested group actually reverted to drugs more often than the 47 percent figure suggests, but their drug use was not detected, hence not controlled.

In the control group, without Nalline testing, 69 percent received prison sentences or jail terms in excess of 90 days, within 18 months, as compared to 53 percent for the experimental group. However, of those in the experimental group who were not given new prison sentences or jail terms of 90 days or more, within 18 months after their release on parole, about three-quarters had been committed one or more times for the 90-day counseling program in prison. This incarceration did not count either as a new sentence or as a parole violation. Of the addicts who were confined for this counseling program and were reparoled—sometimes two or more times within the 18-month follow-up period—about 20 percent avoided relapse to drug use for 6 months or more.

While it is not conclusively established that this program of counseling and close control reduced the rate of renewed narcotics usage, it did permit prompt apprehension of those who returned to drug use. Apparently this reduced the extent to which parolees committed crime in order to support addiction. The similar drug-use rates for those in the experimental program and those in the control group with testing suggest that the main impact of the special program comes from the testing, rather than the counseling.[11]

The Narcotics Treatment-Control program was followed, and largely replaced, by the civil commitment of addicts to the California Rehabilitation Center at Norco, which opened in 1961. This commitment is by order of any county superior court and may be imposed on anyone who voluntarily requests treatment for addiction, or is convicted of a misdemeanor or a nonviolent felony and is then found by the convicting court, on advice of two physicians, to be an addict. In the latter development, the case is transferred from the convicting court to another superior court for the civil proceedings.

---

[11] For a fuller account of the experimental program, see California Department of Corrections, Research Report No. 19, *Narcotic Treatment-Control Program, Phase I and Phase II*, Sacramento: The Department, May 1963.

Following the U.S. Supreme Court decision in the Robinson case,[12] which forbade treating addiction as a crime in itself, the California law was amended in 1963 to eliminate all phraseology like "sentence" or "parole". Paragraph 6399 of Chapter 11, Title 7, Part 3 of the California Penal Code, now reads: "It is the intent of the Legislature that persons addicted to narcotics, or who by reason of repeated use of narcotics are in imminent danger of becoming addicted, shall be treated for such condition and its underlying causes, and that such treatment shall be carried out for nonpunitive purposes. . . . Persons . . . who are uncooperative with efforts to treat them . . . nevertheless should be kept in the program for purposes of control."

The 1963 amendment made the term of confinement or supervision independent of whether the person committed himself or was committed following a conviction. A "Narcotics Treatment Evaluation Authority" was established to replace the parole boards as the releasing agency in these cases. The term "released to outpatient status" now is used instead of "parole" for this release process, although the outpatient treatment involves supervision in 30-man caseloads and compulsory Nalline testing, much like the Narcotics Treatment-Control Program. However, the duration of return to inpatient status is determined on an individual case basis by the new Narcotics Treatment Evaluation Authority, instead of being for the 90-day term. Persons committed after felony or misdemeanor convictions are returned to the sentencing court after they complete three years of narcotics-free outpatient status, and the court may then sentence them for their offense or discharge them. Persons committed voluntarily may be discharged by the Authority at any time. Thus far, the program has survived tests of its legality by appeals through the California Supreme Court, but it is too early to assess the program's effectiveness.

Casework Programs for Addicts in the Community

Programs of counseling for addicts in the community are of two major types: one consists of government-sponsored programs in which some element of compulsion frequently is employed to insure participation; the other consists of voluntary programs, often organized by ex-addicts, in which the only compulsion consists of expelling those persons who do not conform to prescribed standards of behavior. The latter will be dealt with separately, as mutual aid organizations.

Special counseling and assistance programs for parolees and probationers with histories of narcotic addiction have been established in Philadelphia, New York, California, and other localities. The New York program involved the creation of special narcotic caseloads, of small size, assigned to specially selected parole officers. This provided closer attention to the addict's needs than would be possible under

[12] *Robinson* v. *California, op. cit.*

ordinary parole supervision conditions. Funds were made available to the officers for emergency economic assistance to these parolees, including money to "buy" jobs at private employment agencies which guarantee a *bona fide* referral to those who pay in advance.

Analysis of experience on this project suggests that it was markedly successful in reducing the number of offenses or other parole violations by narcotic parolees, but the rate of relapse to narcotics use was almost the same as that of narcotic parolees released in the preceding year under ordinary parole supervision.[13]

The Philadelphia program provides a narcotic testing program in conjunction with a series of carefully defined supervision methods. Four types of supervision are provided varying in caseload size, intensity of counseling, and frequency of contact. Preliminary results indicate that testing clearly acts as a deterrent to future drug use. Although still too early to establish definitely, intensive counseling, group and individual, seems to also result in lower failure rates both during the parole period and after.[14]

A feature of the California program includes a special "Halfway House" for addicts released to parole in the Los Angeles area. This establishment is operated jointly by the California Department of Corrections and the Los Angeles State College under a grant from the National Institute of Mental Health. Addicts live in the center while seeking their first employment and receiving initial counseling. When they seem to be progressing, they procure housing on their own in the community but maintain contact with the "Halfway House" for counseling purposes. A careful evaluation of the effectiveness of this program is planned.

Mutual Aid Organizations of Ex-Addicts

Perhaps the first mutual aid organization of addicts consisted of Narcotics Anonymous, an organization founded at the Federal hospital at Lexington, and modeled on Alcoholics Anonymous. Similar groups have been established in several cities, some of which are called Addicts Anonymous. This organization has not received much special study or publicity, so it is difficult to evaluate. Possibly the severity of our laws on drug usage make it inexpedient for these organizations to publicize their activity as much as Alcoholics Anonymous has done.

A highly publicized mutual aid program for addicts is Synanon House, established at Santa Monica, California, in 1958. The first location provided residence for some 50 ex-addicts. Three more have since been established—in Reno, Nevada; Westport, Connecticut; and

---

[13] State of New York, *30th Annual Report of the Division of Parole of the Executive Department*, Albany: Legislative Document 1960, No. 111, pp. 30–32.

[14] Kurt Konietzke, "Interim Report of the Philadelphia Parole Narcotic Project, Phase I and II," Pennsylvania Board of Parole, July 1964.

San Diego, California. Synanon is a self-governing corporation, and has an auxiliary organization of "Friends of Synanon," which includes many prominent nonaddicts from Los Angeles and its suburbs. Several faculty members from the nearby University of California at Los Angeles have spent considerable time with this group.

Synanon is supported primarily by contributions, including extensive contributions of day-old or surplus food from stores and restaurants, and contributions of furniture and clothing, as well as legal and medical services. The organization encourages nonaddict visitors, especially at its daily luncheon discussions and its Saturday night nonalcoholic and nondrug parties. Senior members of Synanon also do much public speaking at schools, churches, and service clubs throughout Southern California. It certainly has made a contribution to greater public acceptance of ex-addicts and sympathy for their problems.

Both sexes are included in Synanon residences, with the women's bedrooms on a separate floor. There are also branch houses, including one with children of addicts and their parent or parents, for addicts when they have progressed sufficiently to be reunited with their families. These ex-addicts do all the work of operating their establishment, including collecting the contributions by truck.

When new addicts arrive at Synanon they are not allowed to leave at all for several months, and for some months after that they may only leave in the company of those who have been there longer. When they are more advanced, they may procure jobs or attend school in the adjacent community, and they then make financial contributions to the house, but they also are expected to open a savings account. In the final stage, they may move out of the Synanon House, but they are expected to remain in frequent communication with it.

The name Synanon was adapted from an uneducated addict's mispronunciation of "seminar." The label was adopted for a special kind of intensive counseling session conducted by the residents several times a week in small groups. These mix old and new residents, and emphasize breaking down the rationalizations and deceptions with which addicts mislead themselves and attempt to fool others.[15]

Considerable uncertainy as to the effectiveness of such mutual aid programs is warranted, despite their impressive success with certain individuals. Those who remain in the organization seem clearly to have terminated the use of narcotics, sometimes after many years of addiction. However, those who lapse or otherwise fail to cooperate while in the program are ejected from the establishment, so that these

---

[15] Lewis Yablonsky, "The Anticriminal Society: Synanon," *Federal Probation*, vol. 26, No. 3 (September 1963), pp. 50–57. Rita Volkman and Donald R. Cressey, "Differential Association and the Rehabilitation of Drug Addicts," *American Journal of Sociology*, vol. 69, No. 2 (September 1963), pp. 129–142.

failures are not visible. Secondly, it seems evident that, like Alcoholics Anonymous, mutual aid programs are particularly attractive to the more literate addicts. These include disproportionately those of middle class background and self-educated former long-term prisoners. Although all races and national groups are represented in the membership of Synanon, it includes conspicuously fewer persons of Spanish descent than one would expect from the total of California commitments.

A third criticism is that these organizations do little to culminate the cure of addictions by integration of the addict into a nonaddict social world. The addict becomes increasingly dependent on his Synanon relationships. For many, it becomes a substitute family, and the members apparently continue for years to feel socially deprived and alienated when in the outside world among persons who are neither addicts nor ex-addicts.

Many ex-addicts are known whose cure involved establishment of a successful career and happy family life after a complete break with all addicts, following release from a prison or hospital. Probably most of the young narcotics patients and prisoners of past years, who no longer appear in official records as older patients or prisoners, were cured by such assimilation into nonaddict society, where their past now is unknown. This suggests that mutual aid societies are not the only cure for addiction, as some imply, although they may be of special value for some cases.

U. S. GOVERNMENT PRINTING OFFICE : 1968 O - 315-970